The PREVENTION CONNECTION
NEWSLETTER

Children's Mental Health:
A Complex Story that Needs to be Told

—Tracy Velazquez

Walk by a school playground, and what do you see? Lots of kids having fun, playing, shouting . . . just being kids. And yet, around one out of every ten children and adolescents in the United States—over 20,000 children in Montana alone—suffer from serious emotional and mental disorders that significantly impact their lives at home and at school. Children's mental health is a complex issue, largely because of the interplay between biological and environmental factors at critical points in a child's life.

Many children suffer from emotional disturbances that have resulted from or been compounded by trauma, neglect and abuse. The Montana Mental Health Association recently completed an informational video about children's mental health. Some of the young people interviewed for the video revealed that an individual in their family had committed a crime such as rape or illicit drug use that had had a profound negative impact on them. Many of these children have difficulty forming bonds and trusting relationships. Some go on to abuse drugs to try to escape their feelings, while others manifest their troubles through destructive patterns of behavior. Many of these children have been removed from their homes, and are in foster homes, group homes and residential treatment facilities. By no means, however, are all children in residential facilities the victims of abuse or neglect. Montana spends around $13 million per year in residential treatment services and another $12 million in therapeutic group home services; the state spends an additional $4 - $5 million in therapeutic family services, including therapeutic foster care.

The other kids just like treated me like I'm contagious. They invented "Grace Germs" and if they touched me or talked to me, they would catch it . —Grace, MMHA Children's Mental Health Video

I lived in such a world of ups and downs and I would go to school and I'd cycle between really happy and really sad like 5 or 6 times in one day. And it's just, it's just a huge extreme challenge. —Jennifer, MMHA Children's Mental Health Video

These children are only part of the story. More and more research is pointing to adolescence as a time when many major mental disorders—such as depression, anxiety disorders, bipolar disorder and schizophrenia—begin to manifest. The onset of a serious mental illness can be as early as 7 to 11 years old.

Children in middle school who have been labeled troublemakers may actually be struggling to understand and cope with an emerging

Continued on Page 3

Children's Mental Health & Prevention I

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.prevention.mt.gov

Director
Vicki Turner
(406) 444-3484
vturner@mt.gov

VISTA Leaders
Tiffany Roman
406-444-3925
troman@mt.gov

Abigail Zent
(406) 444-9655
azent@mt.gov

PRC Technician
Steve Tielking
(406) 444-9654
STielking@mt.gov

The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@bresnan.net
www.sherriedowning.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: kdgrafix@acegroup.cc

Receiving duplicate copies?

Please help us eliminate unwanted or duplicate mailings by correcting and returning the mailing address listed or by contacting us with the number listed above your mailing address. Thank you!
Phone: 406-444-3484
E-mail: vturner@mt.gov

Need extra copies?

Please feel free to make copies or to download and print the Prevention Connection at prevention.mt.gov.

The Vicki Column

Nature or nurture . . . environment or biology?

Human beings are complex creatures, shaped by biology and experience. If mental illness is factored into the equation, confusion and turmoil have fertile grounds on which to bloom. This issue of the *Prevention Connection* tackles one of the most difficult topics we've discussed to date: children's mental health and prevention. It's an interesting combination. Prevention speaks to what we've learned about nurturing our children and to raising them in an optimum environment, the communities they grow up in and the activities and caring adults they're exposed to.

It's too bad that isn't all there is to it. Children's mental health—and its reverse, mental illness—may be one of the least understood equations of our times. Mental illness rises from singularly individual combinations of biology and environment, nature and nurture . . . experience, psychology and neurochemicals. We can count on one thing: no two individuals will ever respond identically to a given combination of experiences.

The nature versus nurture debate is an old one, revolving around the factors that contribute to the mental development of an individual. Nature (the biological or genetic makeup of a person) or nurture (how a person is raised, by whom, and in what environment) are never just the same for two children, even those growing up in the same family. Just as children inherit certain physical traits from their biological parents, they can also inherit certain mental characteristics and traits as well. This can include the propensity for certain mental disorders. Nurture—or lack thereof—can also mean that children are not being effectively parented. This can be multi-generational when parents did not receive the nurturing *they* needed then or the support they need now.

> ***First we need to deal with the mental health of the mom, then we can deal with the mental health of the kids.* —Marcia Vollmer *(Vicki Turner's mother)***

We've tried to include a good mix of articles that speak to mental health issues and to prevention. We quickly discovered that this topic is so broad and so complex that we could not begin to do it justice in one issue. For that reason, we'll be following this issue with Children's Mental Health and Prevention II.

What we hope to offer with this issue is some insight into some specific mental disorders, what that can look like in the context of the family and the peer group, the frequency of co-occurring disorders and the very real threat of suicide among young Montanans. We've coupled this with good examples of what we know is working—quality early childhood education, cutting edge information on infant mental health, home visiting, school-based mental health services and good out-of-school time programs. If you see something that we've missed, please get in touch. This issue is so broad, so complex and so pervasive that we would welcome your input for the follow-up issue.

By the Numbers

The Surgeon General's 1999 *Report on Mental Health*, in referring to youth ages 9 to 17, states that "21 percent or one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year," with about 11 percent of all children experiencing significant impairment and about 5 percent experiencing "extreme functional impairment."

— At the time of the 2000 Census, there were 230,062 children aged 17 or younger in Montana. Using the 21 percent figure would mean that about 48,312 experienced the signs and symptoms of a DSM-IV disorder during the course of a year.

For more information, visit: http://smhp.psych.ucla.edu/pdfdocs/prevalence/youthMH.pdf

Children's Mental Health

Continued from cover

mental illness. They might try to gain control over their lives by attempting to control their eating and go on to develop eating disorders. Others may find it difficult to sit through classes because of the swings associated with bipolar disorder. Some turn to alcohol and other drugs to alleviate depression or anxiety. Approximately half of students with a mental disorder who are aged 14 or older drop out of high school.

Tragically, only about 20 percent of children and adolescents with mental disorders are identified and receive mental health services in a given year. Parents can find it difficult to get a correct diagnosis, and often face tremendous obstacles when searching for appropriate care. Many parents live in fear that their child will commit suicide when they aren't there to stop it. This is not an unrealistic fear: in Montana, suicide is the second leading cause of death for youth ages 15 – 24, and research show that 90 percent of those who die by suicide suffer from a diagnosable and treatable mental illness at the time of death.

Tim Callahan of the Cascade County Juvenile Probation, is quoted in the MMHA video saying, "We have trouble getting kids into care quickly. Some of the case management services that are available to kids . . . if I call today it might be two weeks before they can get the service, and for a family in crisis that's really unacceptable. The problems we have in the urban centers are a lot worse in rural settings because they have very few services available locally." Tim Callahan, Cascade County Juvenile Probation

When dealing with children's mental health, a number of themes emerge: the need for early intervention and treatment, and the stigma of mental illness for children and families are two. On a positive note is the System of Care, currently under development in our state. Recovery is possible for children, and kids with troubled backgrounds or severe mental illnesses can go on to lead productive lives.

The story of children's mental health can be very difficult to tell. It's difficult to talk about children's mental illness in a way that doesn't minimize the very traumatic lives some children had experienced, yet also doesn't create the impression that "bad parents cause mental illnesses." But it's a story that absolutely needs to be told, for the future of Montana's kids.

***I am hopeful for the future because I know I don't want to turn out like my parents so I can achieve my goals throughout life and I know I can do it.* —Theresa, MMHA Children's Mental Health Video**

—Tracy Velazquez is Executive Director of the Montana Mental Health Association, which educates and advocates for the mental health of adults and children in Montana. She can be reached at 406-587-7774 or: tracy@montanamentalhealth.org.

The Montana Mental Health Association has produced a 15-minute video that includes interviews with youth, parents, and individuals from the Kids Management Authority (KMA) on the Crow Reservation, as well as providers and others who work with emotionally disturbed kids. It is touching and uplifting, and tells of the struggles these kids and thier families face and how they were able to get the help they needed. The generosity of these young people and their families in sharing their stories for the benefit of others is extraordinary.

DVDs of the video are available for groups across the state to help educate the public about the need to improve our system of care and to reduce the stigma of mental illness. To obtain a video, contact the Mental Health Association at 406-727-6642, or e-mail: info@montanamentalhealth.org.

By the Numbers

- *More than 1.3 million children under the age of 18—or one out of 50—received mental health services in the U.S. (Update, 2002).*
- *The most common diagnoses were: disruptive behavior disorders, mood disorders and adjustment disorders. Almost 40 percent were "seriously emotionally disturbed," using the most stringent definition provided by DHHS.*
- *Half of the youngsters studied had problems with family (50%); nearly half (46%) had problems such as eating disturbances, sleep problems, grief and loss reactions, or posttraumatic stress—warning signs of depression or anxiety.*
- *In addition, 44 percent had problems coping with school; and 41 percent had problems with aggression. Nearly one quarter (24%) threatened or attempted suicide, while fully 20 percent were victims of abuse or neglect.*

Source: Data from the 1997 Client/ Patient Sample Survey conducted by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service Administration (SAMHSA) Center for Mental Health Services (CMHS).

Notes from the Edge
My Son: a Parent's Story

I wish everyone who comes in contact with my son now could have known who he was before his illness took over. His past life—growing up and all through high school—were quite successful. He was a law-abiding kid, had great grades, was kind, generous . . . and he volunteered to boil Easter eggs for the Knights of Columbus for seven years. He's polite and has a great sense of humor. He's smart and intellectual. It's every parent's dream is to have a child like this one was, full of life and fun. He gave 18 years of happiness to everyone he knew. He mentored at elementary schools, was a great athlete, and was voted MVP Outside Linebacker by his teammates. As an All-State Outside Linebacker in Fall 2003, he had numerous colleges and universities looking at him for their football programs, but he had decided to go out as a walk-on for the University of Montana football team—the Griz.

That didn't happen.

The onset of his mental illness struck him at the end of his senior year in high school—June 2004—the prime of his life and a time when his world seemed to be opening like a smorgasbord of opportunities. He had a great future ahead of him, but that is lost.

As parents, we hoped he was just going through a rebellious stage, as many teenagers do . . . that he was trying to break into his independence. We tried to get help right away when we noticed his behavior was changing his senior year, but the counselor said that it was normal for young men to pull away from their families. The counselor was wrong. We were all wrong. None of us recognized what was really going on.

We just didn't know about mental illness.

My son's first long-term hospitalization was in December 2004. He hated it. He did not believe he had a mental illness, but I was in denial, too. I certainly did not *want* to believe it. After 91 days, he came home, continued therapy and substance abuse treatment. He was compliant about taking his medicine, he was working and everything seemed to be going great. He was going to try football at a small school in the fall. We were enthused and relieved . . . until we started noticing that his behavior was changing. He had gone off his medicine. Things snowballed from there—the voices started and a manic phase took over.

The first week of November 2005, in a manic phase, he was found in British Columbia, Canada. Believing it had broken down, he had abandoned his vehicle. It hadn't. He believed he was going to live off the land in the middle of Montana and that people were after him. Thank God the Royal Canadian Mounted Police recognized his symptoms. They put him in an ambulance and sent him two hours away, to a hospital in Prince George. We retrieved him and brought him home. To make a long, long story short, he was still in denial about his illness. As his mother, so was I.

The illness led to another commitment to Montana State Hospital (MSH), Thanksgiving 2005. Because our son was not "severe" enough to keep by the standards of the law, he was released. He took off without being stabilized and was in a manic state. He was angry at us and angry at the world that thought he had an illness. In his mind, he didn't. It was *us*, not him. He was gone for about a month. We were terrified that he was not all right . . . wondering if he was hurt or dead. It haunted our family every minute of every day.

I don't blame my son for being angry. I would be angry, hurt and confused, too, if someone told me at age 19 that I had an illness that will affect me for the rest of my life. That the medicine I needed would affect my ability to function athletically—stopping any hope of playing college football in its tracks. I would be angry knowing that the medicine I needed would cause all sorts of side effects, guarantee limitation on the jobs I could work at or even be considered for. At 19, my son had been condemned to isolation, discrimination and a lower quality of life. To top it off, he won't be able to afford the medicine he needs without some type of assistance . . . and that still won't cover it all.

As a mother, I was angry, too. I was angry at God for letting this happen. I kept

Continued on Page 5

What is Mental Illness?

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.

Mental illnesses can affect persons of any age, race, religion or income. Mental illnesses are not the result of personal weakness, lack of character or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

In addition to medication, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups, and other community services can also be components of a treatment plan that assists with recovery. The availability of transportation, diet, exercise, sleep, friends and meaningful activities contribute to overall health and wellness, including recovery.

Source: What is Mental Illness: Mental Illness Facts. www.nami.org

Notes from the Edge

Continued from Page 4

asking *why: why* had God taken a perfect child and let this happen? Why and *how*? As a mother, I denied, denied, denied. This couldn't be true . . . it must be a football injury or something else. But finally, I had to ask myself *why not*? We all struggled, but we finally came to terms with the fact that we were dealing with a mental illness.

Approximately a month after his release from MSH, my son showed up again. It was December 23, 2005. He came to his stepfather's business at about 4:30 p.m. He was so far gone . . . he had decompensated mentally. He had mutilated his arm so badly that it was infected and had burn marks up and down.

I asked him what had happened to his arm and he looked at it and shrugged, "There's nothing wrong with my arm."

I looked at my husband and said I was going to the police. That they would *have* to take my son to the hospital, and that the hospital would have to keep him now. I also knew that they *had* to keep him if we were going to save him. That night, the police would have picked him up, but they couldn't find him.

On Christmas Eve, at about 1:30 p.m., I saw my son driving in the car next to me. I called the police to come get him. I gave the location and the direction he was headed. But no one could find him to pick him up . . . no one could get him to the hospital on Christmas Eve, 2005.

Sometimes I still find myself thinking, *If they would have only kept him at Thanksgiving for a little while longer, maybe they could have stabilized him*. And . . . *if only this* or *if only that* . . . .

On December 25, 2005 another Montana city inherited a problem from our hometown. Maybe all of this happened because of personal denial, lack of services, systems broken. I tried to get help for him. God how I tried.

Our son tells me now that people with a mental illness don't know what they are doing at the time of crisis . . . that you have to find a way to get them the help they need because they can't do it for themselves. No matter what it takes to get them help, he says to just do it.

The blame has stopped. I have worked hard to turn my pain around, to use it to help my son and others like him. I'm trying to make their lives better in some small way.

With my son's knowledge and acceptance, my husband and I have become volunteers at different events that relate to mental illness. We've attended Family to Family classes offered through the National Alliance for Mental Illness (NAMI). I actually had to attend classes twice because my denial of this illness was so overwhelming. My hope is by volunteering it will help reduce the stigma on mental illness, so this horrible struggle won't happen to another family.

I refer to mental illness as a cancer that never quits growing. You keep on suffering, not only physically, but mentally. You don't receive cards, flowers or chocolates when you are in the hospital. Your friends don't visit you, and when you are released, your friends abandon you. You're lucky if your family is still there for you.

To change our behavior, we must first recognize that change needs to take place. My son had no choice but to come to terms with his illness at a young age, in the most unfortunate of circumstances. Admitting his struggles and accepting his illness were victories in themselves. I think that he has come to terms with this illness, and accepts that his life will be different than he earlier dreamed. My only hope, as his mother, is that my son can go on to live a quiet, healthy, stigma-free life.

It is estimated that mental illness affects 1 in 5 families in America.

Some of the Facts

— *Mental illnesses are biologically based brain disorders. They cannot be overcome through will power and are not related to a person's character or intelligence.*

— *Mental disorders fall along a continuum of severity. Even though mental disorders are widespread, the main burden of illness is concentrated in a much smaller proportion—about 6 percent, or 1 in 17 Americans—who suffer from a serious mental illness.*

— *The World Health Organization has reported that four of the 10 leading causes of disability in the US and other developed countries are mental disorders.*

— *Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.*

— *Without treatment, the consequences of mental illness are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives.*

— *The economic cost of untreated mental illness is more than $100 billion each year in the United States alone.*

— *The best treatments for serious mental illnesses today are highly effective: between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.*

Source: What is Mental Illness: Mental Illness Facts. www.nami.org

The Debilitating Stigma of Mental Illness

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there were an estimated 21.4 million adults aged 18 or older with serious psychological distress in 2005. Among 18-25 year olds, the prevalence of serious mental health conditions is almost double that of the general population, yet this age group shows the lowest rate of help-seeking behaviors.

In Montana, the stigma associated with being diagnosed with a mental illness can be debilitating in itself. Mental illnesses are not socially acceptable illnesses to disclose the way we might disclose diabetes or cancer. When someone discloses a mental illness, friends or loved ones often pull away, act uneasy or become avoidant. This leads to increased isolation and a decreased chance of recovery from the mental illness.

The Substance Abuse and Mental Health Services Administration (SAMHSA) launched the National Mental Health National Anti-Stigma Campaign to encourage, educate and inspire people between 18 and 25 to support their friends who are experiencing mental health problems. The good news is that this group can minimize future disability from mental illness if social acceptance is broadened, and if the right supports and services are delivered early on.

Recovery is more likely in a society of acceptance. This initiative is meant to inspire young people to serve as the frontline in a move toward social change and acceptance. Mental health recovery is a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community while striving to achieve his or her full potential.

This work is important. Discrimination and stigma have made it harder and harder for people with mental illnesses to keep a job, find a home, get health insurance, and find treatment.

If somebody told you he had diabetes, how would you react? If you're like most people, you'd express sympathy and concern, offer your support and reassurance, and feel confident that your friend's condition would improve with treatment. If that same friend told you he had a mental illness, what would you do?

Too many people respond negatively when confronted with a friend's mental illness. This fuels the stigma surrounding the diagnosis. The reality is, mental illness is no different from physical illness. Conditions like depression, schizophrenia, and anxiety disorders affect the body. The emotional and psychological aspects of mental illness make supportive friends and family even more important to recovery.

Being there to offer reassurance, companionship, emotional strength and acceptance can make a difference. Mental health problems can affect anyone at any time, so everyone needs to understand how mental illnesses can affect individuals, families and communities. It's also why we need to learn how to support our friends who live with a mental illness.

For more information on this campaign, visit www.whatadifference.org/.

One of the keys to recovery from a mental illness is connection and support from friends and family. Social isolation, resulting from stigma, creates the opposite effect. Stigma often prevents people from seeking appropriate treatment they need.

What do we mean by stigma?

From the American Heritage Dictionary:

1. A mark of disgrace or infamy; a stain or reproach, as on one's reputation.

2. A mental or physical mark that is characteristic of a defect or disease: the stigmata of leprosy.

Stigma is discrimination on the basis of a label. The stigma of mental illness often comes down to stereotypes and discrimination . . . shaming labels . . . misunderstanding.

Labels aren't always negative. A medical diagnosis is, in essence, a label. This kind of label can offer reassurance that a condition has a medical cause, and can help steer an individual or family toward appropriate treatment. Some illnesses, however, remain on the social fringe—shunned, mocked, disrespected and discredited. For many, being diagnosed with a mental illness is akin to wearing a scarlet letter, an invitation for scorn and disdain.

Stigma has four components:

1. Labeling someone with a condition

2. Stereotyping people with that condition

3. Discriminating against people on the basis of a label.

4. Creating a division—a superior us and a devalued them, resulting in loss of status

For more information, visit: http://www.mayoclinic.com/health/mental-health/MH00076

Living With Fetal Alcohol Effect

Based on an interview with "Tiffany" by Athena Schritz

When did you find out you had Fetal Alcohol Effect (FAE)?

My brother Cliff was tested first. Then Joel and I were tested. We were all diagnosed.

Was it a relief to finally know that you had Fetal Alcohol Effect?

Before there was a lot of confusion. No one knew that my brothers and I had FAE, so we didn't know what was causing problems in and out of school. I had a hard time accepting FAE. In eighth grade I accepted that I would have to learn to live with it. There were no medications or surgery that would lessen FAE's impact on my life.

What are some of the ways that Fetal Alcohol Effect impacts your daily life?

I have to write everything down. I have a list of all my appointments in an appointment book at home and at work. I also write them on a piece of paper that I keep in my purse. I set my clocks 10 minutes ahead to keep on time. I go shopping with a list that I take to the grocery store, so I don't forget what I need to buy. I also had a payee who helps me manage my money. My payee gave me a weekly allowance, paid the bills and put some money in saving. Now I am my own payee. I had trouble with daily tasks, like remembering to shower and brush my teeth. I have most of that, but I had to learn to remember to do them.

In addition to Fetal Alcohol Effect, you have also struggled with Bipolar Disorder.

Being down was the hardest. I was always tired. I could not feel, so I started cutting myself to feel . . . even if it was pain. I was suicidal.

What was the strategy for managing your Bipolar Disorder?

Therapy and medication. As I have gotten older, I have been able to manage without mediation. I have not had a relapse like in high school. I hope it does not come back, but my mom says it could.

Your parents have raised three sibling groups with mental health issues. What was it like living in your home?

Becky and Brian were the first to come. Mom and Dad sat us down and explained what they had experienced and what we needed to do to make them welcome and take care of them. James and Jamie were next. They were hardest because they had such a hard life before coming to our home. Mom and Dad said James and Jamie were head bangers. I thought that meant they listened to hard rock music. Their head banging was different. One time James hit his head so hard he left a hole in the wall. As we got older and lived together, we learned from each other.

What programs have you participated in that have given you the skills to be successful?

My parents and the school system helped me through school. Getting through school was a struggle, but I am so glad that I did. After I turned 18 and moved out, I was in AWARE. It teaches life skills to youth leaving foster care. The second program was BRIDGES. It's a life skills program for people learning to cope with brain injuries. Many people were recovering from brain injuries that came from accidents or strokes. I was learning to cope with a brain injury I was born with.

—Athena Schritz is a former Prevention Resource Center VISTA Leader.

What are FASDs?

Prenatal exposure to alcohol can cause a range of disorders, known as Fetal Alcohol Spectrum Disorders (FASDs). One of the most severe effects of drinking during pregnancy is Fetal Alcohol Syndrome (FAS), a permanent condition characterized by abnormal facial features, growth deficiencies, and central nervous system problems. People with FAS might have problems with learning, memory, attention span, communication, vision and/or hearing. These problems often lead to difficulties in school and problems getting along with others.

Fetal Alcohol Spectrum Disorders (FASDs) is an umbrella term describing the range of effects that can occur as a result of prenatal exposure to alcohol. These include physical, mental, behavioral and/or learning disabilities. FASDs include FAS as well as other conditions in which individuals have some, but not all, of the clinical signs of FAS. Three terms often used are: Fetal Alcohol Effect (FAE), Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol-Related Birth Defects (ARBD).

Children with FASDs might be small in relation to peers; have facial abnormalities such as small eye openings; poor coordination; hyperactivity; learning disabilities; developmental disabilities (e.g., speech and language delays); low IQ; problems with daily living; poor reasoning and judgment; and sleep and sucking disturbances in infancy.

Children with FASDs are at risk for psychiatric problems, criminal behavior, unemployment and incomplete education. These secondary conditions can be serious, but certain protective factors that have been found that can mitigate the effects. For example, a child diagnosed early can be placed in appropriate educational classes and given access to child- and family-centered social services. Those who receive special education are more likely to achieve their developmental and educational potential. Loving, nurturing and stable homes can reduce the chances of disruption, transient lifestyles and harmful relationships. Children living in abusive or unstable homes or who become involved in youth violence are much more likely to develop secondary conditions.

Source: Centers for Disease Control and Prevention. www.cdc.gov/ncbddd/fas/fasask.htm

Integrating Mental Health and Substance Abuse Treatment

—Tim Myers

"Wow! Four new referrals today. Did you get a chance to read through them?"
"Sure did. Talk about some survivors. It breaks my heart to read some of those charts."
"Any cutters?"
"Two cutters—one with multiple assaults."
"Well, let's hope the program can help them identify some healthier ways to cope."

Shift change discussion would often go something like this during my days as a rehab aide for an adolescent inpatient drug and alcohol rehabilitation facility. Kids came in our doors with a presenting problem of alcohol dependence, cannibis dependence or methamphetamine abuse. These are the diagnoses our program was designed to treat. At the same time, the overwhelming majority of patients who land in inpatient drug and alcohol treatment come with a history of abuse and a resulting Axis I diagnosis. The unfortunate truth is that dual diagnosis or co-occurring clients are the norm at the adolescent inpatient level, so programs are being forced to adjust their treatment models to meet their clients' needs.

In the past, traditional treatment methods for drug addiction and alcoholism were intense and confrontational. They were designed to break down a client's denial, defenses, and/or resistance to his or her addictive disorders, as perceived by the provider. In contrast, traditional treatment methods for mental illness have been supportive, benign and non-threatening, designed to maintain the client's already-fragile defenses.

Motivational interviewing (Miller and Rollnick, 1991) brings mental health treatment philosophies to substance abuse treatment by stepping away from traditional treatment methods in a number of ways, most notably, they:

- forego traditional treatment-readiness criteria and begin at the client's stage of readiness/motivation and degree of symptomatology.
- do not utilize intense, confrontational interventions in response to denial or resistance.
- advocate the need for the development of trust as essential to the treatment process.
- advocate acceptance, empathy and respect for the client's perceptions, beliefs and opinions.
- tolerate disagreement and dispel moral and judgmental beliefs.
- do not interpret relapse as treatment failure, or employ punitive consequences.
- convey and/or provide a hopeful vision, a belief in the possibility of change, and support self-efficacy.

Motivational interviewing is the current industry standard for this generation of substance abuse treatment. It represents the evolution of substance abuse treatment to comprehensive mental health treatment that meets clients "where they are at." As one who has faced the reality of dual diagnosis and the need for integrated programs adapted to the needs of severely mentally ill chemical abusers, I espouse continued movement in this direction for inpatient treatment centers.

Making the observation that those requiring an inpatient level of care for substance abuse treatment are more often dual diagnosis clients led me to search out a treatment model specifically for dual diagnosis clients. The *Sciacca Treatment Model for Dual Diagnosis* (Sciacca, K. 1997) was developed for a New York State psychiatric facility as a treatment approach for mentally ill chemical abusers.

In Sciacca's model, the phase-by-phase interventions from "denial" to "abstinence" begin by assessing the client's readiness to engage in treatment. Readiness

Continued on Page 9

Children in Vulnerable Families

The Urban Institute recently released Children in Vulnerable Families: Facts and Figures, a new fact sheet that examines trends in the risks facing families today, including child maltreatment, domestic violence, children's disabilities, substance abuse and parental mental illness. These risks affect 28.5 million children.

The share of low-income children living with a parent with symptoms of poor mental health remained relatively stable between 1997 and 2002, fluctuating between 24 and 26 percent (affecting between 17.5 and 18.8 million children). For children in higher-income families, this share ranged from 10 to 11 percent (affecting between 7.2 and 8 million children).

The data in the fact sheet are drawn from the US Department of Health and Human Services, US Census Bureau, Child Trends Data Bank, and various Urban Institute publications.

Access the fact sheet at: http://www.urban.org/publications/901016.html

Integrating Mental Health . . .

Continued from Page 8

levels are accepted as starting points for treatment, rather than points of confrontation or criteria for elimination. Mental health and substance abuse programs that integrate these programs implement screening forms to identify clients who have dual disorders. Those who are identified are targeted for engagement and readiness assessment.

In this model, clients are encouraged to participate in dual diagnosis treatment even if they do not accept or agree with the presence of a substance disorder. Clients may participate on the basis of their interest in learning more about mental health and substance disorders, or with the belief that they may be able to lend support to others who are seeking help, among other reasons. The process proceeds from identification to engagement.

The objective in the engagement phase is to develop comfortable and trusting relationships and, if possible, to expose the client to information about the etiology and processes of these illnesses in an empathic and educational manner. The client is given the opportunity to critique the information presented as versus being told particular facts. The interactive effects between symptoms of mental illness and substance disorders are included in this exploration. Clients at this phase are not required to disclose personal experiences or to admit they use or abuse substances until they are comfortable doing so.

The inclusion of educational materials and discussion topics allows for discussion of the issues and for impersonal participation. Clients are encouraged to move along a continuum from "exploration" to "acknowledgment" of their symptoms. This includes:

- attaining a level of trust necessary to discuss their use of substances and/or symptoms of mental illness;
- the exploration and subsequent discovery of any problems or interaction affects that result from substance use and mental health symptoms;
- consideration and motivation for addressing these problems;
- active engagement in a process of treatment that seeks to eliminate symptoms;
- attainment of partial or full remission; and
- participation in an individualized maintenance regime for relapse prevention.

These programs are implemented as components of existing mental health, and substance abuse programs, and thereby provide integrated treatment.

Knowledge of continued development towards more fully integrated mental health and substance abuse programs brings hope to this somber soul, who oftentimes wonders how much those suffering from the "double trouble" of dual diagnosis can get from a treatment model designed for the more fortunate.

—Tim Myers is a student in the MSW program at the University of Montana at Missoula.

Substance Use Disorders & Adolescent Development

Developmental tasks associated with late adolescence and early adulthood include dating, marriage, child bearing and rearing, establishing a career, and building rewarding social connections. Younger adolescents take the first steps along this path by separating from their parents, developing a moral code, and aligning themselves with different segments of their community. Although some experimentation is normal, sustained use of substances will likely interfere with the demands and roles of adolescence and make it more difficult to negotiate the transitions from early to late adolescence to young adulthood. Because substance use changes the way people approach and experience social interaction, the adolescent's psychological and social development are compromised, as is the formation of a strong self-identity.

To help teenagers who have substance use disorders, the problem must first be identified. Health professionals, educators, and others who come into regular contact with adolescents have the obligation to use appropriate, effective, and respectful means to identify potential substance use problems among adolescents. Screening and assessment procedures must be followed by sensitive, direct treatment and interventions as indicated by the test results.

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders, provided as a service of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* presents information on identifying, screening and assessing adolescents who use substances. Adolescents differ from adults physiologically and emotionally and are transitioning from child to adult. Although experimentation with substances is common, substance abuse can seriously impair development, leaving an adolescent unprepared for the demands of adulthood. It is therefore important for a wide range of professionals who come into regular contact with adolescents to recognize the signs of substance use.

TIPS and a variety of other resources can be accessed online at: *http://csat.samhsa.gov/publications.aspx*

Trauma, Mental Illness and Substance Use Disorders

Research on trauma demonstrates that many mental health and substance abuse clients have experienced a traumatic event. Traumatic events—emotionally distressing events outside the range of normal human experience—can include child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents. Although many recover from their traumatic experiences, some develop post-traumatic stress disorder (PTSD) and/or other clinically impairing disorders.

Trauma can result in vulnerability to other mental illnesses or substance use disorders, and conversely, mental illness and substance use disorders increase the risk of trauma. Regardless of the onset or origin of the psychological trauma, mental illness or substance use disorder, professionals in the mental health and substance abuse fields are becoming more cognizant of the scope of these co-morbid problems and how they complicate treatment. Clients with a history of trauma are more likely to have a substance use disorder, have more severe psychiatric symptoms, and use more costly psychiatric services.

Source: Trauma among people with mental illness and/or substance abuse disorders: Missouri Institute of Mental Health, Policy Information Exchange.

http://mimh200.mimh.edu/mimhweb/pie/reports/mimh_policy_reports.htm

Jason

—Nathan Munn

What is it like to be a youth suffering from a mental illness? We use terms like serious emotional disturbances, co-occurring disorders, multi-systemic treatment plans . . . but what do these *feel* like? The stigma of mental illness can be especially difficult for adolescents, who seem to value their peers' opinions even more than those of adults. Symptoms can be seen and felt, but hard to describe. Family history is close and painful and time seems to go on forever. Whatever an adolescent is feeling at the moment is what he's felt always—or so it seems. So when hopelessness appears, it is tough to see beyond it or to recall times when hope was there.

The following fictional story is meant to offer a snapshot of the dynamics and reality for an adolescent struggling with a Severe Emotional Disturbance (SED).

A campfire lights the forest. Teenagers are gathered and rap music throbs. Jason and his girlfriend, Bree, talk at the edge of the light. He's upset.

"Bree, please don't leave."

"You're mental, dude," sneers Bree. "Hey Robbie, let's ride!"

Bree gets in Robbie's car and they drive away. Jason watches them go, struggling against tears as his cousin Jenny walks up to him, carrying two beers.

"Hey, Cuz," Jenny says, startling Jason. "Calm down. Want a beer?"

"She's gone." Jason moans. "I'm mental. I should never have gone to that place."

"Hello—you did try to kill yourself. The hospital helped. You know it did. Before that you'd be all happy like *yee-haw* and running around all night. Then you'd crash. I wouldn't see you for weeks."

Jason takes a swig of beer.

"My dad takes meds and it's cool. Better than . . . ", she pauses.

"My dad. Blew his brains out. I know. I found him, remember?"

"Well, it looks like your meds help to me and Mom. Gramma is all happy you take them. And your mom . . . well, she'll be happy, too."

"When she comes home from treatment? Right. That'll last."

"Maybe this time it will."

"Maybe."

"Jason, you're freaking me out. You OK? Maybe you should go see Dr. Miller. She's cool."

"She is cool, smart and way busy. It takes forever to get in to see her. I can't get an appointment for a month." Jason swigs the last of his beer and throws the bottle in the fire. Sparks fly.

"I'm flunking school, my probation officer's riding my ass, and now Bree's run off with Robbie. It just ain't worth it." Jason walks toward the darkness.

"Where you going?" Jenny calls.

"I've got my mom's gun."

"Shit!" Jenny runs after him. Grabs his arm. He flings her off.

Jenny runs to the fire. "Hey! Jason's suicidal!"

Jason, now behind the steering wheel of his car, slams the door. He puts his keys in the ignition, hesitates, starts it. He looks down at the passenger floorboard, at his mother's pistol.

Later, Jason sits at a picnic table, alone, car parked on the path behind him. He's bouncing the gun in his hand, fingering the trigger. Tears roll down his face.

He holds the pistol up, cocks it.

Involved in and confused by several systems, being in care but needing more access coupled with the sudden loss of a relationship could precipitate collapse for nearly anyone. Having an SED, though partially treated, makes it far more difficult. Co-occurring disorders factor being drunk or high into the equation. Hopelessness hits like a knife in the heart. Suicide can seem appealing, a viable option.

There is hope. Increased coordination among providers can decrease confusion. Improved monitoring of symptoms can guide medication trials. Therapist availability equates to options. Looking for and acknowledging co-occurring disorders, such as substance abuse, can open doors to chemical dependency treatment. And of course, there are natural supports—family, friends—that come into play. By understanding the suffering of the children and adolescents we are helping, we can overcome obstacles and provide effective, coordinated care. We *can* save lives.

Some Common Diagnoses

Pediatric Bipolar Disorder is marked by extreme changes in mood, energy, thinking and behavior. Symptoms may be present from infancy or emerge in adolescence.

Persistent states of extreme elation or agitation accompanied by high energy are called mania. Persistent states of extreme sadness or irritability accompanied by low energy are called depression. The illness may look different in children than it does in adults. Children usually have an ongoing, continuous mood disturbance that is a mix of mania and depression. Rapid and severe cycling between moods produces chronic irritability and few clear periods of wellness between episodes. Diagnosis is made using the DSM-IV criteria, for which there is no lower age limit. For more information, see the Child and Adolescent Bipolar Foundation at www.bpkids.org.

Anxiety disorders are among the most common mental, emotional and behavioral problems to occur during childhood and adolescence. About 13 of every 100 children and adolescents ages 9 to 17 experience some kind of anxiety disorder; girls are affected more than boys. About half of children and adolescents with anxiety disorders have a second anxiety disorder or other mental or behavioral disorder, such as depression.

Researchers suggest watching for signs of anxiety disorders when children are between the ages of 6 and 8. During this time, children generally grow less afraid of the dark and imaginary creatures and become more anxious about school performance and social relationships.

Other mood disorders: The essential features of mood disorders are the same in children as in adults, although children exhibit symptoms differently. Unlike adults, children may not have the vocabulary to accurately describe how they feel and therefore may express their problems through behavior.

Some estimates suggest that 7 to 14 percent of children will experience an episode of major depression before the age of 15. Out of 100,000 adolescents, 2,000 to 3,000 will have mood disorders. Recent epidemiologic studies have shown that a large proportion of adults experience the onset of major depression during adolescence and early adulthood.

The depressed child may pretend to be sick, refuse to go to school, cling to a parent or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is going through a temporary phase or suffering from depression. For more information, visit the National Institute for Mental Health (NIMH) at http://www.nimh.nih.gov.

Oppositional defiant disorder may be a precursor of conduct disorder, which is also known as a "disruptive behavior disorder" because of its impact on children, families and community. A child is diagnosed with oppositional defiant disorder when he or she shows signs of being hostile and defiant for at least 6 months. Oppositional defiant disorder may start as early as preschool, while conduct disorder generally appears when children are older. Conduct disorder affects between one and four percent of 9- to 17-year-olds, depending on how the disorder is defined. The disorder appears to be more common in boys than in girls.

Symptoms include: aggressive behavior that harms or threatens other people or animals; destructive behavior that damages or destroys property; lying or theft; truancy or other serious violations of rules; early tobacco, alcohol, and substance use and abuse; and precocious sexual activity. Children with conduct disorder or oppositional defiant disorder may also experience higher rates of depression, suicidal thoughts, attempts and suicide; academic difficulties; poor relationships; difficulty staying in adoptive, foster, or group homes; and higher rates of injuries, school expulsions, and problems with the law. For more information, visit www.mentalhealth.samhsa.gov/publications/allpubs/CA-0010/default.asp

Ready to quit?
Call 1-866-485-QUIT

Smoking and exposure to second hand smoke are the first and third leading causes of the preventable deaths of Montanans. Both significantly increase the risk of developing lung cancer, heart disease and stroke. Spit tobacco is a major risk factor for oral cancer. Additionally, smoking during pregnancy has a multitude of negative health impacts on the mother, the fetus and the newborn. Quitting tobacco use significantly reduces the risk of premature birth and premature death.

Tobacco use quit lines provide counseling and nicotine replacement therapy (NRT), proven to be effective cessation services. The Montana Tobacco Use Prevention Program has partnered with the National Jewish Medical and Research Center in Denver, Colorado to provide free quit line services in Montana. Callers to the quit line can receive: self-help cessation education material; four weeks of NRT; a motivational intervention; and a five session counseling program

Quit line services can be accessed by a toll free telephone number or through a fax referral from a health care professional. Persons who enroll in the phone counseling program regardless of income or health insurance status are eligible to receive 4-weeks of free NRT through the mail.

For more information, contact Stacy Campbell at 406-444-3138 or visit Montana Tobacco Prevention at http://tobaccofree.mt.gov

. . . from the edge

I didn't fully accept the bipolar diagnosis . . . I didn't like the diagnosis. I couldn't believe the psychiatrist told me that. I just thought it was because he was lazy and didn't want to treat me.

I was on drugs, too, at the time, and I don't think you can accurately diagnose bipolar disorder when someone is actively drug addicted or alcoholic.

So maybe I was taking drugs to keep the monster in the box.

I'm fine, but I'm bipolar. I'm on seven medications, and I take medication three times a day. This constantly puts me in touch with the illness I have. I'm never quite allowed to be free of that for a day. It's like being a diabetic.

Bipolar disorder can be a great teacher. It's a challenge, but it can set you up to be able to do almost anything else in your life.

—Carrie Fisher, author of Postcards from the Edge and The Best Awful, based on her own diagnosis with bipolar disorder.

Montana's System Transformation

—Deb Sanchez

Vision: *People of Montana with co-occurring disorders will be welcomed into an accessible, comprehensive, compassionate service system that is focused on prevention and recovery.*

Co-occurring disorders are generally defined as at least one mental disorder and at least one substance use disorder, which a person has at the same time. The federal Substance Abuse and Mental Health Services Administration reported in 1999 that approximately 10 million people in the United States have co-occurring substance and mental disorders. The prevalence of co-occurring disorders is higher in public service systems (e.g., substance abuse treatment, mental health treatment, criminal justice) than in the general population.

We now know that *co-occurring mental and substance use disorders need to be treated at the same time*, rather than separately or sequentially.

To create a vision for integrated system development, the Addictive and Mental Disorders Division adopted the Comprehensive, Continuous, Integrated System of Care model in 2001. The goal of CCISC is to build a system of care that is welcoming, accessible, integrated, continuous and comprehensive from the perspective of consumers and families.

To make vision a reality, Montana has a strategic action plan that includes the following goals:

- Create awareness of co-occurring disorders and the need for an integrated service system.
- Create an integrated service system.
- Develop a centralized data management system.
- Develop clinical capacity and competence.
- Create a financing plan for the integrated service system.

To learn more, visit the AMDD website – http://www.dphhs.mt.gov/amdd/

—Deb Sanchez is the Adult Mental Health Community Program Manager for the Addictive and Mental Disorders Division of Montana's Department of Public Health and Human Services. She can be reached at dsanchez@mt.gov.

Principles of CCISC

Co-occurring disorders need to be thought of as "the expectation, not the exception" in public service system settings. This expectation must be incorporated in a welcoming manner into all clinical contact, to promote access to care and accurate identification of the population.

Treatment success derives from the implementation of empathic, hopeful, continuous treatment relationships, which provides integrated treatment and coordination of care through the course of multiple treatment episodes. Within the context of the empathic, hopeful, continuous, integrated relationship, case management and care are based on level of impairment. Empathic detachment or confrontation are based on strengths and contingencies, and are appropriately balanced at each point in time.

When a substance disorder and a psychiatric disorder co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended. In this way, each disorder receives appropriately intensive diagnosis-specific treatment. Both substance dependence and serious mental illness are primary, chronic, biological illnesses, which can be understood by using a disease and recovery model, with parallel phases of recovery.

There is no one correct treatment approach for individuals with co-occurring disorders. For each individual, interventions must be matched according to the need for engagement, level of impairment or severity, specific diagnoses, phase of recovery and stage of change. Likewise, there is no one correct outcome measure for individuals with co-occurring disorders. Abstinence must not be used as the only measure of success.

(Dr. Ken Minkoff, 2001)

A FRESH START

—Cheri Peterson, LCSW, LAC

Being an adolescent in today's world is not easy: teens face pressures from parents, peers, society and media. It is often difficult to sort out how to do well in school and still be "cool," knowing when you're thin enough, pretty enough, smart enough, too smart, or whether you can play sports without looking like a geek. In addition, many teens fear the possibility of school violence, feel pressure to plan their futures at an early age and to take on responsibilities beyond their developmental abilities. Couple any of these issues with substance abuse, mental illness, lack of positive family or community support and it's easy to see why some teens find their worlds crashing down around them.

Most adolescents who experiment with alcohol and other drugs can be identified and helped through education such as Minors in Possession programs or outpatient treatment. Others are not able to manage and find themselves in a vicious cycle of using alcohol or other drugs to escape elements of their world that are confusing, frustrating or unbearable. These teens escape their feelings and thoughts through substance use, sometimes using *to not have to feel*, while others use to *be able to feel again*. Sometimes, the only way to help is to offer a reprieve from the day-to-day chaos and a chance to clear their heads, literally and figuratively.

The Teen Recovery Center (TRC) opened its doors on August 14th, 2005. Since then, it has served more than 140 adolescents. While teens must have a primary diagnosis of chemical dependency to be accepted into the program, many have underlying mental health issues that may or may not have been previously identified or addressed. Even teens who *have* been diagnosed with disorders such as depression, bipolar disorder, ADHD and oppositional defiant disorder may not have stayed clean long enough to address their symptoms, recognize their triggers or allow psychotropic medication an opportunity to take effect.

When teens arrive at TRC, they receive a full mental health evaluation and a physical examination. Our program encourages each individual to make an effort to exchange their daily practices for healthier ones, starting with a 6:30 a.m. wakeup and a 45 minute workout before showers. Daily group therapy for chemical dependency provides an understanding of addiction and helps residents recognize their triggers. They begin to learn the process of recovery and about building a positive support system. Residents participate in life skills training and art therapy five times a week, as well as practice daily goal setting and meditation. They also pursue their educational requirements with a certified teacher who provides instruction on site. Various community programs provide further education, including tobacco cessation, health education, media literacy and weekly AA and NA meetings.

Since family support is such a critical element of success among adolescents with chemical dependency and/or mental health issues, family therapy is provided on weekends and on a monthly family education day. Families identify the importance of their involvement in the recovery process and gain tools for communicating effectively with their teens. Often, a behavioral contract is completed between the teen and family prior to discharge. This is coupled with a detailed discharge plan that identifies follow-up recommendations.

Unfortunately, adolescents returning to the environment they struggled with in the first place may have little opportunity for successful sobriety. Some teens acknowledge that their isolated communities, lack of follow-up treatment, limited positive peer groups and, occasionally, lack of family structure and support, will inhibit their abilities to build a positive future. Our staff works closely with the youth, the family and the referral source to explore alternatives after completing TRC. Some teens choose to enter the Job Corps, Montana Youth Challenge or a group home that will offer guidance toward independent living. Many residents maintain regular contact with TRC after discharge through telephone calls and letters, often just seeking words of encouragement or to report on their progress.

If you know of a teen who could benefit from Teen Recovery Center, please contact Kim Brown-Haugen, Intake Coordinator, at 721-5379.

—Cheri Peterson is the Director of Adolescent Programs for Turning Point and Director of Teen Recovery Center.

I just wanted to thank you all for helping me overcome all of my struggles. I know that this is not the end of it, but you all have guided me down a positive path. I will really miss all the fun activities we did and all of the staff that I bonded with. Just know that you are the one treatment center that makes adolescents want to change. I didn't like it at first but you really know how to make a person's self esteem rise and I thank you for that so much. I can now be myself out in the real world and not care what people say about me. So once again thank you for everything you have showed and taught me. Love always and forever, T.B.
—From a letter that TRC received from a resident after she returned home.

The Teen Recovery Center (TRC) is a residential treatment facility located just outside Missoula. This program of Western Montana Addiction Services (Turning Point) accepts up to 8 teens at a time, between the ages of 13 and 19. The program is a minimum of 35 days, and Medicaid, CHIP and most insurance plans are accepted. State funds are available for qualifying families.

Suicide in Montana

—Drenda Carlson

—There is no cure for this plague except death. I am trying to do my best at life, but there are to many bad things in the world to stop me. I want to live in heaven with God. If something doesn't love me, I will die now. Let me out of the trap." —a 12-year-old to his psychotherapist

According to the Centers for Disease Control (CDC), in 2003, Montana was 4th in the nation for suicides overall and 3rd for suicides among young people between the ages of 10 and 24. The Montana rate of 13.78 per 100,000 is more than double the national average of 6.65 per 100,000. For both age ranges, 10-14 and 15-24, suicide is the number two cause of death in Montana (National Center for Health Statistics).

The 2005 Youth Risk Behavior Survey reveals that youth in Montana are thinking about, making plans for, and attempting suicide at startling rates. In the twelve months prior to taking the survey, 15 percent of 7th and 8th grade students and 18 percent of high school students reported having considered suicide. Twelve percent of 7th and 8th grade students and 10 percent of high school students reported actually attempting it.

When focusing on the statistics, the picture looks grim and prevention looks like an overwhelming task. Thankfully, there are dedicated individuals in communities throughout our state. With a National Strategy and a State Strategic plan in place for guidance, 12 communities will utilize federal Garrett Lee Smith Act grant monies, received through the Department of Public Health and Human Service, to build and solidify local suicide prevention programs.

Many communities will implement or expand QPR (Question, Persuade, Refer) gatekeeper training to increase awareness of suicidal ideation and to give individuals in the community the skills they need to assist with treatment referral and follow-up. These communities will also implement evidence-based prevention strategies approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Suicide Prevention Resource Center. Columbia University TeenScreen and Emergency Room Suicide Intervention for Adolescent Females are two of the evidence-based programs Montana communities will execute to address the high suicide rates among youth and young adults.

Many of the funded communities will introduce awareness campaigns around National Suicide Prevention Awareness Week and National Depression Screening Day. Some are proposing free screenings at public health fairs with referrals to treatment and follow-up by local professionals.

Most of the twelve funded communities will develop coalitions, advisory councils or critical response teams to create crisis response plans and strategic plans. This will help motivate communities to address the suicide issue and move forward one small step at a time with goals and objectives.

Without question, that we have highly dedicated and competent partners across the State of Montana in our fight against suicide. I have no doubt that one day in the near future we will see the impact of the hard work being done.

—Drenda Carlson is the Adolescent Health and Youth Suicide Prevention Consultant with the Department of Public Health and Human Services. She can be reached at 406-444-6858 or dcarlson2@mt.gov.

Source of initial quote: Advancing Suicide Prevention: January 2006, vol. II, Issue I, pg. 21.

The 12 Garrett Lee Smith Act Grant Recipients are:

– Flathead City-County Health Department

– Lewis & Clark City-County Health Department

– Missoula City-County Health Department

– University of Montana on behalf of the Fort Peck and Rocky Boys Indian Reservations

– Yellowstone City-County Health Department

– Cascade City-County Health Department

– District II Alcohol and Drug Program, located in Sidney and serving five counties

– Confederated Salish Kootenai Tribes Voices of Hope

– Indian Development and Educational Alliance of Miles City

– Western Montana Mental Health Center in Hamilton.

Participating communities will focus on prevention, intervention and postvention. A broad spectrum of objectives include: increasing access to prevention initiatives and programs; increasing access to mental health services; raising awareness that suicide is a public health issue; and tackling the stigma around asking for help, especially regarding mental health issues.

Map of the nine top suicide states

Depression, Mental Illness and Suicide in Adolescents: *A review of three articles**

—David M. Young, Ph.D.

Uncovering an Epidemic[1]

According to Richard A. Friedman, M.D., mental illness is a silent epidemic among American teenagers, with the majority of cases going unrecognized and untreated. Sadly, the extreme outcome of unrecognized and untreated cases is suicide—the third leading cause of death among youth between the ages of 15 and 19. The National Co-morbidity Survey reveals that half of all serious adult psychiatric illnesses – including depression, anxiety disorders, and substance abuse—start by 14 years of age and that three fourths are present by age 25. According to the Centers for Disease Control and Prevention (CDC), in 2005, 16.9 percent of U.S. high school students seriously considered suicide, and 8.4 percent had attempted suicide at least once during the preceding year. Early detection of primary risk factors for suicide—mood disorder, a previous suicide attempt and alcohol or substance abuse—can be identified and treated.

A large school-based mental health screening program, Teen-Screen, was used in 42 states in 2005 and involved 55,000 young people. Teen-Screen is voluntary, confidential, and requires parental consent. Of the 55,000 youth screened in 2005, about one-third were positive on the questionnaire and about half of those were referred for further evaluation.

Studies have shown that children and adolescents are very secretive about their feelings and that parents are unaware of 90 percent of suicide attempts made by teenagers. In fact, the majority of teens who attempt suicide give no warnings to parents, siblings, or friends. Dr. Friedman believes that mental health screening of teens should be universal, going beyond school-based screening to involve pediatric clinicians.

Familial Pathways to Suicidal Behavior[2]

Drs. Brent and Mann discuss familial pathways to suicidal behavior in adolescents. They propose a stress-diathesis model diagram for adults that, along with the familial transmission of vulnerable abilities to suicidal behavior, may help explain and predict suicide among young people. Studies have shown that many teenagers who attempt suicide have limited ability to regulate mood, tolerate distress, problem solve or control inappropriate behavioral responses. Others show signs of impulsive aggression, hostility, hopelessness and depression. From a research perspective, neurocognitive functioning, working memory, accurate assessment of risk and problem solving have been found to correspond to regional alterations in the brain in persons who have attempted suicide. Drs. Brent and Mann believe that future treatment studies should incorporate neurocognitive indicators of risk, as well as interventions aimed at altering core vulnerabilities.

Antidepressant Quandary[3]

Dr. Simon reviews the benefits and risks of using antidepressants in children and adolescents. He stresses the fact that Fluoxetine is the only drug with a clearly established antidepressant effect in a pediatric population. It is also the only drug approved in the U.S. for the treatment of depression in children and adolescents. Dr. Simon underscores the disappointing fact that in spite of a dramatic increase in the use of antidepressants among both adults and children during the past 20 years, the outcomes of depression treatment have changed very little. Dr. Simon offers four specific recommendations that physicians should consider discussing with patients and families when planning treatment of depression in a child or adolescent.

—David M. Young is a Professor at Montana State University and a Rural Health Resource Specialist with the MSU Extension Service. He can be reached at: dyoung@montana.edu

Suicide Prevention Resources

Indian Health Services Suicide Prevention Website
http://www.ihs.gov/NonMedicalPrograms/nspn/

Suicide Prevention Resource Center
http://www.sprc.org/

Montana Mental Health Association
http://www.montanamentalhealth.org/

American Foundation for Suicide Prevention
http://www.afsp.org/

Suicide Prevention Action Network – USA
http://www.spanusa.org/

Montana Suicide Prevention
http://www.montanasuicide.org/

Centre for Suicide Prevention
http://www.suicideinfo.ca/csp/go.aspx?tabid=23

National Adolescent Health Information Center
http://nahic.ucsf.edu/

Mental Health Screening
http://www.mentalhealthscreening.org/

1-800-273-TALK
www.suicidepreventionlifeline.org

Sources:

The articles reviewed appeared in the December 28, 2006 issue of the New England Journal of Medicine.

1. Friedman, R.A. Uncovering an Epidemic—Screening for Mental Illness in Teens. NEJM 2006; 355:2717-2719.
2. Brent, D.A., Mann, J.J. Familial Pathways to Suicidal Behavior—Understanding and Preventing Suicide among Adolescents. NEJM 2006; 355:2719-2721.
3. Simon, G.E. The Antidepressant Quandary—Considering Suicide Risk When Treating Adolescent Depression. NEJM 2006; 355:2722-2723.

Infant Mental Health

—Pam Ponich-Hunthausen, LCPC

Even as a die hard "strength-based" therapist, when I hear the term *mental health* I tend to think about mental health issues or the problems associated with mental and emotional well-being. When I first heard the term *Infant Mental Health*, I must admit I was appalled that there was actually an area of clinical study and expertise devoted specifically to the mental health problems of babies. (*Babies*??!!)

Oh brother, I thought, *here we go again, over-pathologizing and over-labeling to the degree that we have started calling babies mentally ill!!* I mean, they're not even walking or talking and already we've relegated them to a life fraught with stigma, repeated medication trials and a system that is chronically undervalued and underfunded? Now there's a cheery prognosis for a newborn.

Even so, having spent the past few years of my career working with the young moms and babies at the Florence Crittenton Home in Helena, I was intrigued by the concept. What I have discovered about the newly emerging field of Infant Mental Health has not only settled my cynical fears of over-zealous drug companies trying to tap into a new market of bipolar three-month olds, it has actually put much of what I know about healthy human development into a professional and philosophical niche that makes sense, while providing a good foundation for clinical practice.

The concept of Infant Mental Health is simple. On a very basic level it speaks to the quality of social and emotional development in the first years of life. For infants and toddlers, this entails the capacity to form close, secure relationships, to experience, regulate and express emotions, to explore the environment and to learn in the context of family and cultural expectations. While the more tangible influences of such things as food, shelter and medical care are significant to the healthy development of children, we know that the more subtle influences of caregiver/child relationships profoundly impact how children grow and develop on emotional and relational domains. The field of Infant Mental Health is a multidisciplinary approach to enhance these aspects of development.

Decades of research and clinical practice have shown that healthy parent/infant attachment and the quality of early relationships with caregivers are the cornerstones of socio-emotional growth of children. They are necessary to prevent and heal infant mental health concerns. The bonding and attachment process actually begins before a child is born and continues to develop in the first years of life. The significance of a safe, stable, predictable and nurturing environment, principly as it relates to the primary caregiver/child relationship, cannot be overstated. It is a powerful predictor of lifelong emotional health. Problems within the parent child relationship and early disruptions in the bonding/attachment process can greatly impede normal, healthy development and may lead to serious mental health issues. Conversely, we know that the provision of a secure, safe and supportive environment for mother and baby set the stage for positive growth and development and can lead to emotional healing as well.

At Florence Crittenton, we embrace the notion that only from a secure base of support, nurturing and consistency can healthy growth, development and healing occur. The pregnant and parenting teens who come to us usually have histories of trauma, abuse, neglect and unstable family environments. Most often, they have never experienced a consistent, nurturing relationship with a parent or primary caregiver and therefore have no model from which to provide a secure base for their children. Their babies are frequently at risk of developing emotional problems themselves. It is the role of the clinical team and staff to ensure that the environment we provide is safe, nurturing and consistent so that these young parents are better equipped, socially and emotionally, to provide the same for their children. From this foundation, these young mothers can become the secure base their children need to safely explore the world, develop healthy identities and enter into healthy relationships with others—in essence, to attain optimal infant mental health.

As a therapist, I have always been honored to have a part in nurturing the positive emotional health of at-risk adolescents. At Florence Crittenton, I am witness daily to the positive power of a healthy environment and relationships and their impact on infant mental health. I feel doubly honored to have the rare opportunity to impact lives and futures, two generations at a time.

Infants and toddlers can develop diagnosable mental disorders and there is an increasing body of knowledge devoted to early identification, assessment, prevention and intervention of and for emotional and behavioral issues specific to this age group. Very young children can be depressed, can have intense anxiety issues, and can display behavioral disruptions that are outside the realm of normal development. The good news is that we are getting better at early assessment and intervention. These young ones don't have to battle their emotional issues for the rest of their lives. With proper and prompt support and treatment, prognoses are so much better than they would be without early intervention.

Pam Ponich-Hunthausen, LCPC, is a therapist with Florence Crittenton in Helena. She can be reached at: PamP@florencecrittenton.org

Home Visiting

—Julie Burk

Do for. Do with. Cheer on.

Those simple words summarize the philosophy of the Lewis and Clark City-County Health Department's home visitors, who work with parents who are at high risk of abusing or neglecting their children. *Do for* means to model positive parenting alongside the client. *Do with* means to handhold, coach, and advocate while families do things for themselves the first few times. *Cheer on* means to lend support as families take healthy steps on their own.

Home visiting programs around the country have diverse goals, but share a focus on the importance of children's early years and on the pivotal role parents play in shaping children's lives. They are also guided by the sense that one of the best ways to reach families with young children is by taking services *to* them rather than expecting them to seek assistance in the community. Home visitors can see the environments where families live, gain a better understanding of their needs, then tailor services to meet those needs.

The Health Department's Home Visiting Program works to improve the health of high-risk pregnant women, mothers, fathers, infants and children. Home visitors are either registered nurses or social workers, along with a lay home visitor, visit clients in their homes. At times, they follow a family from before a child's birth until the child's fifth birthday.

Each home visitor has a caseload of no more than 25 families. More than half the clients are referred by the Women, Infants and Children (WIC) Program. The rest are referred by Child Protective Services, the Office of Public Assistance, private health care providers and the clients themselves.

According to Program Coordinator Greg Daly, who has been with the Health Department since 1994, most clients struggle with mental illness, which is compounded by poverty, isolation, and trauma.

"We engineer community support so our clients can parent their kids in the best way possible," he said. "We concentrate on helping parents develop emotional self-management skills because who takes care of the kids? Parents do."

Parents in the voluntary program have had "adverse childhood experiences that have rendered them unready to parent," Daly said. "That means neglect, abuse, family trauma and attachment issues. These are non-attached adults who have never experienced healthy parenting. We work with fathers and mothers to help them recognize and build on existing strengths."

The mental health status of at-risk families compromises their ability to respond to their kids' needs, Daly said. "People have old wounds that interfere with parenting. Poverty, overwhelming stress and life situations outside their perceived control create parents who desperately struggle to manage their own lives. When parents' basic needs go unmet, children suffer. The home visiting model interrupts this cycle. We are voluntary, and that is crucial."

The county's home visiting program provides parents with social support; practical assistance (often in the form of case management that provides links to other community services), and education about parenting and child development.

Daly said that there are no quick fixes for his clients, but that the home visiting model is an effective form of prevention and early intervention that pays off.

In Helena, Daly said that the program pays for itself by keeping kids out of emergency rooms, and by reducing the risk of preterm labor and associated expensive medical treatments to premature babies.

"Our program also reduces the incidence of child abuse and neglect that has life-long health costs," he said. "We help develop healthy tax-paying citizens who give back to the community as they graduate from the program."

"No one bats 1,000, and we are in partnership with all the wonderful social services in our community. It is said that a high-risk traumatized person needs to encounter seven significant people to overcome the negative effects of her background," Daly said. "There's nothing mysterious about what we do. We've seen this work over and over again. When people succeed, it is infectious. They will raise their kids differently than how they were raised. They become a contributing part of the community. And *that* is success."

—Julie Burk, MPA, is a Development and Public Information Specialist with Lewis & Clark City-County Health Department. She can be reached at

Mental Health: A Report of the U.S. Surgeon General, published in 1999, states "children are at risk for developing mental disorders or experiencing social-emotional problems if they are prenatally exposed to alcohol, illegal drugs and tobacco; and external factors such as poverty, deprivation, abuse and neglect."

Home visiting is about generations learning to attach, grow and participate in relationships.

According to a 40-year longitudinal study conducted in Ypsilanti, Michigan, the money spent on home visiting services is well spent. The estimated return on investment is $17 in benefits for every $1 in costs. In addition, the study showed that adults who had received home-visiting services as children were better educated, had higher incomes, had a higher rate of home ownership, and a lower crime rate than children who did not receive services.

School Readiness = Prevention

—Mary Jane Standaert

Ensuring that a child is ready for school and life is the prevention connection that is the most successful. Throughout 2006, the Head Start Collaboration Office focused on nationally developed school readiness formula.

Early childhood is defined as the period of a child's life from conception to age eight. Early childhood programs include child care centers, family and group homes, teen parenting programs, Head Start, Early Head Start, preschools, kindergarten through third grade, recreational programs, family literacy and other programs. They typically include an array of services that spans health, mental health, education, home visiting, consultation, and a variety of services and interventions for those with specific needs.

Many, if not most, of these programs are funded by federal grants. Others use state general funds or private tuition, while still others blend funding streams. A wide spectrum of quality is found in early childhood services because there are no set standards for all to adhere to. The most comprehensive and stringent standards are found in Head Start and in the accreditation standards for early childhood programs through the National Association for the Education of Young Children (NAEYC). All of these programs can be considered prevention programs, but not all adequately prepare children. This is the reason our work is focused on school readiness. If so many programs and services are available for young children and their families, why are so many children unready to start school, or getting a few years in and failing to thrive? What is missing and what can be done?

Ready Families
+ Ready Services
+ Ready Communities
+ Ready Schools

Children Ready for School

In September 2005, the Head Start Collaboration Office took the lead in coordinating Early Childhood Comprehensive Systems (ECCS) grant for Maternal and Child Health. We successfully combined ECCS duties and priorities into those of the Head Start Collaboration work because they are so similar. We partnered with the Governor's Office to submit two grants, which were subsequently awarded by the National Governor's Association (NGA).

The first NGA grant hosted two Governor's Summits on School Readiness; while the second leadership grant focuses on Montana's early childhood system. The Governor's Summits brought 14 community teams to Helena in June; business leaders gathered in Missoula in October. Both raised awareness about the importance of investing in our very youngest children *before* they reach school. The community teams and state staff developed action plans and identified public awareness as a priority. Community teams were awarded small grants to put their action plans into motion. Business leaders identified numerous things they could do to best support families and young children.

The Governor, First Lady Nancy Schweitzer and the Governor's policy advisors are champions for all young children and families in Montana. The Dennis and Phyllis Washington Foundation, in recognition of the importance of the earliest years in a child's life, has committed to being a partner in this endeavor and helped host the business summit.

While we all value children, government policies and funding have a tendency to ignore infants, toddlers and preschoolers except for those with exceptional needs, when in fact our greatest efforts and strongest safety nets should be cast in the earliest years to save time, money and effort later on. Community leaders, schools, teachers, service providers and families need to be the appropriate skills, care, information and support *from the beginning*.

The NGA leadership grant provides an opportunity to address the systems that serve families and young children. We will be asking some tough questions, such as *What needs to happen in order to be more effective and timely? Who is responsible for what? What could be done differently and by whom? What needs to be communicated to administrators, staff, the general public and parents?* While some of this work has occurred in the past in different venues, this time, all parts of the early childhood system are present. Additionally, we have technical assistance from and accountability to the NGA. Most importantly, we have support and guidance from the Governor's Office.

As a result of the work being done in the early childhood arena over the past year, a Montana School Readiness Task Force has been formed. The Task Force has a big job to do. You can help Montana be a leader for young children. Please take a minute to review the school readiness formula. Think about what you do and how you directly or indirectly touch the lives of young children. Ask yourself what could be done differently, what could be better coordinated, enhanced, delegated or even discontinued? Then let me know what you think—call, e-mail or send a note. With your help and advice, I know that together we will ultimately support the services you provide for families and children. I look forward to hearing from you.

—Mary Jane Standaert is the Director of the Head Start/State Collaboration Office and the Coordinator of the Early Childhood Comprehensive Systems Project. She can be reached at 406-444-0589 or mjstandaert@mt.gov

The 5 Domains of School Readiness

A child's readiness for school should be measured and addressed across five distinct but connected domains:

1. *Physical well-being and motor development*
2. *Social and emotional development*
3. *Approaches to learning*
4. *Language development*
5. *Cognition and general knowledge*

Early Learning Guidelines for Children of the Big Sky

—Lisa Murphy

Many materials written to help early education practitioners are of the one-size-fits-all variety. It's easy to find books that tell us how to expand on a curricular topic by "taking the children on a field trip using public transportation." It's not as easy to find publications that embrace the way children grow and learn in a rural state like Montana.

Montana's Early Learning Guidelines (MT ELG) are what children between the ages of three and five need to know, understand, and be able to do by the time they reach kindergarten. These guidelines were developed in Montana, for Montana, by Montanans.

The guidelines are written to address what adults can observe in children aged three to five and provide ways to support their development. They are meant to be inclusive of all children and settings where children spend time before elementary school, whether this means home, a child care facility, Head Start, preschool or other settings where children spend their time. Montana's guidelines are modeled after Head Start's Child Outcomes, which were designed to help adults meet children's developmental needs and promote optimum learning for each child.

Early care and education professionals play a key role in early learning. Montana's Early Learning Guidelines offer a model for good practice that helps adults focus on what children can or may be able to do and reinforces the idea that children are capable learners. The guidelines also reinforce the importance of early care and education and emphasize the importance of quality early experiences.

The guidelines are a tool that can help facilitate the flow of information among families, early care and education providers and elementary schools. Two additional documents have recently been printed that help make these connections. Montana *Early Childhood Connections* is a publication that links the Montana Early Learning Guidelines to existing program standards and assists early care and education professionals in understanding how a variety of existing program standards link to the guidelines for children's learning. The most recent publication is the *MT ELG Fun Family Activities*. This is a companion piece for families that recognizes the importance parents and other family members play in a child's growth and development. Most of the activities are designed to fit into a family's day-to-day routines. The book provides a list of children's books appropriate for children ages 3 to 5 and a section that includes recipes for play dough, sidewalk chalk, goop and rainbow stew.

> ***—We can turn out clones and robots who do as they are told, or we can foster a love of learning, produce critical thinkers, and develop creative, socially responsible citizens.***
> **—Margie Carter and Deb Curtis: *Training Teachers: A Harvest of Theory and Practice***

For additional information about any of the Montana Early Learning Guidelines documents contact: Lisa R. Murphy, Early Childhood Program Specialist for the Early Childhood Services Bureau/DPHHS, State of Montana. (406) 444-1400.

Access the guidelines in entirety at: www.montana.edu/ecp/pdfs/MTEarlyLearningGuidelines.pdf

The Ready Child Equation

The Ready Child Equation describes the range of influences on children's ability to be ready for and successful in school:

- *Ready Families describes children's family context and home environment.*
- *Ready Communities describes the community resources and supports, including businesses and charitable organizations available to families.*
- *Ready Services describes the availability, quality and affordability of proven programs that influence child development and school readiness.*
- *Ready Schools describes critical elements of schools that influence child development and school success.*

Children's readiness for school is made up of multiple components and shaped by numerous factors. Improving school readiness, therefore, must address children's development of skills and behaviors as well as the environments in which they spend their time.

Efforts to improve school readiness must address three interrelated components:

1. *Children's readiness for school—physical, emotional and cognitive domains*
2. *Schools' readiness for children—responsive, individualized, inclusive*
3. *The capacity of families and communities to provide developmental opportunities for their young children*

School-Based Mental Health Services

—Bob Runkel, Acting Assistant Superintendent, Office of Public Instruction

—When schools are welcoming places, the school serves an important role in the prevention of children's mental health issues.

Providing a quality education for children requires schools to deliver high-quality instruction. However, for instruction to be effective, schools find it necessary to support students in other ways as well. Schools recognize that physically fit, well-adjusted and well-fed students are better learners. For example, the National School Lunch Program has been meeting the nutritional needs of students for the past 60 years. In more recent years, Montana schools have expanded programs to support the social/emotional and behavioral needs students as well.

It is not uncommon for schools to have concerns for students with behavioral and emotional problems. Serious behavioral problems can significantly interfere with a student's education and the education of others. For this reason, many schools provide behavior management and counseling services and have programs that encourage positive behavior and social skill development. The two most common behavior/mental illness prevention programs found in Montana schools are the Montana Behavioral Initiative (MBI) and Comprehensive School and Community Treatment (CSCT).

MBI

For the past decade Montana schools have been involved in the MBI. The MBI focuses on improving school climate by supporting schools in their effort to create an accepting, supportive environment for all children. Through the MBI process, schools establish a system of positive behavioral supports to increase rates of positive interactions between students and positive interactions with school staff while decreasing behaviors that could lead to students being sent to the principal's office because of behavioral issues.

The MBI facilitates changes to the school system, as well as changes in attitude that may be necessary to meet the needs of today's students. Data is used to help MBI teams determine needs and to evaluate effectiveness. The MBI is not a *program*, but a *process* that guides the task of school improvement.

The goal of MBI is to create a positive, secure and supporting environment for all students. Training on positive behavioral supports is provided for staff and a structured problem-solving team process helps set priorities for programs and activities designed to improve school climate. Proactive efforts developed by community and school personnel identify and prioritize concerns, teach acceptable alternatives to inappropriate behaviors, and create a culture of respect.

CSCT

While the MBI serves as the first tier of prevention for children's mental health issues, the second-tier is a school-based mental health program called Comprehensive School and Community Treatment (CSCT). The CSCT is a collaborative effort of the Office of Public Instruction (OPI) and the Department of Public Health and Human Services (DPHHS). The CSCT is a comprehensive, planned course of treatment provided by Community Mental Health Centers in school and community settings to children with serious emotional disturbance.

CSCT services include behavioral intervention, crisis intervention, treatment plan coordination, aftercare coordination and individual, group and family therapy. Individualized treatment plans tailored to the needs of each student are developed by licensed mental health professionals in coordination with school staff. Services are delivered by a team that includes a licensed mental health professional and an aide. Team members are trained in positive behavioral supports, child and adolescent management techniques, therapeutic de-escalation of crisis situations and research-based behavior interventions and practices.

Community Mental Health Centers working in close cooperation with public schools increase the likelihood education and mental health programs are better coordinated. Teachers often feel more confident when the school has mental health resources available when intervention is needed in the event of a behavioral confrontation with a student. Mental health professionals feel more confident that educators will follow through and support mental health treatment plans. Students feel more secure knowing that the adults are consistent in their support of their behavioral needs.

The CSCT promises to provide an effective program of intervention for students with behavioral challenges. Providing mental health services in a school-based setting has a number of important advantages. The first is access. Busy schedules for parents and students and the cost of transportation often present obstacles to accessing mental health services. By bringing the services to the student in the school setting, it is far more likely that the student will be available to actively participate in the treatment plan.

Perhaps the most significant advantage of school-based mental health services is the simple fact that effective treatment depends on timely interventions. This is especially true with children and adolescents and is often referred to as "teachable moments." Because mental health professionals are present throughout the school day, they are available to intervene and redirect inappropriate behaviors and to teach appropriate behaviors and social skills at each opportunity. This real-time intervention in the natural setting promises to have a major impact on improving the effectiveness of children's mental health services.

Both CSCT and MBI fill an important need in our schools. While the number one priority for our schools is increasing academic achievement for students, schools also know that a key to success is ensuring that our schools are a welcoming place and that students are well-adjusted.

For more information on how MBI can help your school, contact Susan Bailey-Anderson, 444-2046.

For information on CSCT services, contact Rena Steyaert, Department of Public Health and Human Services, 444-4066.

Nuances in Adolescent Development

—Dr. Kirk A. Astroth

Are youth who participate in structured after-school activities (SASAs) better off psychologically, emotionally and socially than youth who do not participate in such programs? New national research indicates that the answer may depend on gender as well as the type of program.

All young people have strengths, as do the environments in which youth experience life. These strengths are the *social nutrients* or *developmental assets* needed for healthy development. When individual strengths are aligned with the community's resources (or assets), positive youth development occurs. Positive youth development (PYD) is often thought of by what are known as the "Six C's"—competence, confidence, character, caring, connection and contribution.

Research has identified that the best youth development programs are marked by the presence of three key components: sustained, positive adult-youth relations; skill-building activities; and youth participation and leadership

Researchers at Tufts University in Boston were engaged three years ago to conduct a large longitudinal study of youth in after-school programs across the nation. The goal was to identify the individual and contextual factors that lead to positive youth development, and ultimately to contributions of the youth studied to self, others and community. More than 4,000 youth and 2,000 parents in 25 states participated in this study to date, Montana included.

In this study, fewer than 10 percent of youth did not participate in any structured after-school activities. On average, youth participated in three different types of after-school activities each year.

The results were very interesting. The positive and negative changes youth undergo across early adolescence vary in relation to gender, socioeconomic status, race, residence and ethnicity. Youth development is complex and comprised of improvements and setbacks throughout the advance to adulthood. Development across early adolescence is diverse, but for most youth, the changes are more complicated—most show increases or decreases in positive *and* problematic behaviors.

Across grades, the greater the number of different types of structured after-school activities in which youth engage, the better their PYD. As we have learned in other studies, "more is better" in terms of after-school programs.

Using the research tools developed in this study, we can begin to assess the likely trajectory of changes youth will show across early adolescence. These patterns of change can help practitioners know where to focus their efforts for optimal impact.

Some of the results from these first three years of study are of particular interest. When looking at those who landed in the high PYD trajectory group, college aspirations were significant. Youth hoping or expecting to graduate from college were most likely to experience a high PYD trajectory in early adolescence. Aspirations for post-secondary education provide hope and strong belief in a positive future.

There are also significant differences between thriving boys and thriving girls. Except in the area of depression, girls are doing better than boys in all program types. Boys were more likely to show externalizing behaviors—fighting, for example. Girls were more likely to show internalizing problems, such as depression. In fact, for girls, there is a general increase in depression across grades 5 to 7, a finding reported in several other longitudinal studies. This study also found that the higher the socioeconomic status of the youth, the higher the PYD and the lower the levels of internalizing or externalizing behaviors—a finding also consistent with other studies.

Adolescent development is comprised of zig-zags rather than straight line trajectories. More data is being collected, and as we learn more, we hope to better understand the influence of after-school program participation and its contributions to PYD and mental health.

To read more about this fascinating study, please visit: *http://www.nae 4ha.org/directory/jyd/current_ issue.aspx*

—Dr. Astroth is the Director of the Montana 4-H Center for Youth Development at MSU Bozeman. he can be reached at KAstroth@Montana.edu

Best Beginnings for a Ready Workforce

Things businesses can do to support healthy child development.

- ***Sponsor parent education classes***
- ***Provide more information regarding childcare and other family services***
- ***Offer flex-time benefits for employees***
- ***Provide on-site childcare***
- ***Support early care and education legislation***
- ***Provide flexible options for parents with sick children***
- ***Build consortiums of businesses to work together on early childhood issues***
- ***Support the expansion of preschools, Head Start and Early Head Start and other quality services for children***
- ***Encourage and support employee volunteerism in programs that serve young children***
- ***Provide part time employees with a regular work schedule***
- ***Allow employees to bring their babies to work***
- ***Accommodate breastfeeding mothers***
- ***Permit employees to work at home when possible and/or necessary***
- ***Become involved with existing programs***
- ***Create job-sharing opportunities***
- ***Promote philanthropic investment in early childhood programs and services***
- ***Supply space to the community for meetings***
- ***Set up pre-tax spending accounts for employees that can be used for child care***
- ***Donate goods and services***
- ***Ask your employees and coworkers how you can support them and their families***

What About All-day Kindergarten?

Some of the Benefits

Mental Health

– Fewer behavior problems, grade retentions and special education placements.

– Significant gains in social and emotional development.

– Long-term studies show reduced use of correctional and social services, higher adult literacy rates, and higher level of schooling completed.

Positive effects on short- and long-term student achievement

– Significantly stronger academic gains over the course of the kindergarten year than their half-day counterparts.

– Levels the playing field for disadvantaged kids who enter school already behind.

– Students exhibit more independent learning, classroom involvement and productivity in work with peers.

– Higher test scores and greater progress in literacy, math, and general learning skills.

What are the effects?

The growing body of research examining the effects of full-day kindergarten suggests that full-day kindergarten programs produce learning gains that are at least as great as, and usually greater than, the learning gains of half-day kindergarten programs. No studies to date show greater gains, academic or developmental, for students in half-day programs over those for students in full-day programs. Additionally, a number of studies focusing on disadvantaged students showed greater learning gains for students in full-day kindergarten programs. Of the limited number of studies of the long-term effects of full-day kindergarten, several suggest that some long-term learning gains exist.

In general, children in full-day programs exhibited more positive behaviors than did pupils in half-day or alternate-day programs. Comparisons between similar half-day and full-day programs in a statewide longitudinal study revealed that full-day kindergartners exhibited more independent learning, classroom involvement, productivity in work with peers, and reflectivity than half-day kindergartners. They were also more likely to approach the teacher and expressed less withdrawal, anger, shyness, and blaming behavior than half-day kindergartners.

What are the characteristics of effective full-day programs?

Montana defines all-day kindergarten as kindergarten every day, all day. Full-day kindergarten allows children and teachers time to explore topics in depth, reduces the ratio of transition time to class time, provides for greater continuity of day-to-day activities, and provides an environment that favors a more developmentally appropriate approach to curriculum. Recent research indicates that, compared with children in formal, academically oriented programs, children in kindergarten programs that provided more child-initiated and informal activities rated their abilities significantly higher, had better expectations for success on academic tasks, and were less dependent on adults for permission and approval.

Experts urge teachers, administrators, and parents to resist the temptation to provide full-day programs that are didactic and academically focused rather than intellectually engaging. Seat work, worksheets, and early instruction in reading or other academic subjects are inappropriate for most kindergarten children. By contrast, developmentally appropriate, informal, intellectually engaging all-day kindergarten programs:

- integrate new learning with past experiences through project work and through mixed-ability and mixed-age grouping in an unhurried setting.
- involve children in first-hand experience and informal interaction with objects, other children, and adults;.
- emphasize language development and appropriate preliteracy experiences.
- make it easier to work with parents to share information about their children, and build understanding of parent and teacher roles.
- emphasize reading to children in school and at home, and set the stage for later parent-teacher partnerships.
- offer a balance of small group, large group, and individual activities.
- assess students' progress through close teacher observation and systematic collection and examination of students' work, often by using portfolios.
- develop children's social skills, including conflict resolution strategies.

Source: *Clearinghouse on Education and Parenting*—http://ceep.crc.uiuc.edu.

The Clearinghouse on Early Education and Parenting (CEEP) is part of the Early Childhood and Parenting (ECAP) Collaborative at the University of Illinois at Urbana-Champaign. CEEP provides publications and information to the worldwide early childhood and parenting communities.

Governor Brian Schweitzer: *On Strengthening Montana*

I believe that full-time kindergarten is one of the best ways to make a lasting difference in the lives of Montana's children and families, especially children who are at-risk. My support does not come lightly, but the *idea* did come unexpectedly while I was attending a Western Governor's Association meeting.

The meeting was focused on workforce development. I had a chance to ask a panel of experts a question: *If you had just one more dollar, how would you invest it?*

I was surprised by the consistency of the answers. It came down to this: *Invest earlier and start young . . . Kindergarten or earlier.* The reasons they gave made sense.

— Students are better prepared for elementary school.

— They have a better chance of graduating from high school.

— They're more likely to succeed in college.

— And ultimately, they will become a successful, skilled workforce.

I came back and studied the research that supports full-time kindergarten. The more I learned, the more convinced I became that Montana schools *must* be able to provide this opportunity to our youngest children. Ultimately, my Education Funding Bill—SB 152—came to include full-time kindergarten.

Education is our competitive edge. I want Montanans to be able to compete in the global economy, regardless of where they live in our state. My administration has a school readiness agenda that incorporates children from birth through 8 years old, and includes full-time kindergarten as a key to ensuring all kids are ready for school. We have to make sure kids have a solid foundation for becoming the workforce of tomorrow.

This is my long-term vision. I've supported it by providing resources to schools and communities, which can then decide if and when full-time kindergarten is right for them. This long-term vision will ultimately reap benefits for many generations to come, long after I've left office.

Montana needs young minds that are ready to change the world. To get there, we must invest in our youth. I want Montana's children to have the very best beginnings during early childhood, so they grow to become the best and brightest in Montana's colleges.

Web Resources

What does the research say about all day kindergarten programs?
http://www.edina.k12.mn.us/district/registration/pdfs/AllDayKResearch.pdf

The Effects of Full Day Versus Half Day Kindergarten: Review and Analysis 2004
http://www.doe.state.in.us/primetime/pdf/fulldaykreport.pdf

Investing in Full-Day Kindergarten is Essential
http://www.strategiesforchildren.org/eea/3research_facts/05_InvestFDK.pdf

Study: Full-Day Kindergarten Boosts Academic Performance
http://www.edweek.org/ew/newstory.cfm?slug=31kinder.h21

Full-Day Kindergarten : Exploring an Option for Extended Learning
http://www.nwrel.org/request/dec2002/kindergarten.pdf

Learning Trend: Kindergarten Becomes an All Day Affair
http://www.csmonitor.com/2004/0129/p01s03-ussc.html

In Context: Issues Surrounding Full-day Kindergarten
http://www.nwrel.org/request/dec2002/incontext.html

Full-day Kindergarten
http://www.scholastic.com/earlylearner/experts/behavior/3_5_fulldayk.htm

National All-Day Kindergarten Network
http://www.siue.edu/~snall/kdtn

The Last Word

—Joan Cassidy, Chief, Chemical Dependency Bureau

Thank you! We received 93 responses to the recent *Prevention Connection* (PC) survey. You gave us some useful suggestions and feedback and you let us know that we're on the right track.

- 95% of respondents said that the PC is a valuable resource for Montana.
- 41% of respondents had been reading the newsletter for at least 3 years.
- Readership appears to be growing: 20% of respondents had been reading it for less than one year, and an additional 25% had been readers for one to two years.
- 64% were also subscribers to the Prevention Resource Center's Hot News listserv.
- 26% asked to be added to the Hot News listserv.

What do you like most about the PC? This question elicited answers from about 2/3 of respondents. Answers broke down across broad categories: the Montana focus and personal stories; access to valuable, reliable information; enhanced awareness; and the bundled collections of articles in theme-based issues.

Respondents were enthused about the themes suggested for upcoming issues. In order of popularity, were: Individual and Family Domains; School and Community Domains; Alcohol; Mentoring and Out-of-School Programs; Juvenile Justice; Making a Difference: Montana VISTAs; Homelessness; Economic Development; and Integrating Faith-based Efforts.

Respondents also shared some additional ideas for upcoming issues: more on alcohol; mental health; intergenerational mentoring; crime and corrections; early childhood; tobacco; healthy communities; media literacy; body image; suicide; parenting; drug abuse and treatment; physical health and disability; and leisure time activities. Most are extremely good fits for the issues approved on the list above.

Finally, suggestions for improvements included more pictures and enhanced promotion of the newsletter, so that more people will know about it. Respondents also asked for more diverse authors and more articles from community members. In response, we'd like to say that we're always open to articles from our readers. Just contact Vicki Turner at VTurner@mt.gov or Sherrie Downing at DowningSL@bresnan.net.

In closing, I'd like to tell you how honored we are by your support, your readership and your contributions. The *Prevention Connection* is an important forum where Montana professionals can speak to other Montana professionals, where we can share what is working, as well as some of the current research and best practices.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

2,500 copies of this public document were published at an estimated cost of $2.98 per copy, for a total cost of $7,460.00, which includes $3,460.00 for production and printing and $4,000.00 for distribution.

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604

**PRSPT
STD RATE
U.S. Postage
Paid
Permit No. 246
Helena, MT**

Change Service Requested